Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AHMED KHALIFA MD
3100 TIMMONS LANE SUITE 250
HOUSTON TEXAS 77027

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
ZENITH INSURANCE CO

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-11-3891-01

MFDR Date Received
July 6, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier refuses to pay full amount due for services rendered even after request for reconsideration was submitted."

Amount in Dispute: $54.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Zenith maintains its position that the NCV/EMG was paid according to the fee guidelines, based on the locality of the physical address where services were rendered."

Response Submitted by: The Zenith

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 13, 2011	99202, 95861, 95900, 95904, A4556	$54.12	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedure for professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 6, 2011 and June 16, 2011
   - A12 W1 – Reimbursement has been calculated according to the state fee schedule guidelines.
   - A6J 97 – Per the fee schedule, cost of this supply is embedded in the value of the procedure performed on this date.

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- W1 – Workers Compensation State Fee Schedule Adjustment

Issues

1. Did the requestor bill for services in conflict with NCCI edit?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks additional reimbursement for CPT codes 99202, 95861, 95900, 95904 and A4556 rendered on April 13, 2011.
2. 28 Texas Administrative Code §134.203 states in pertinent part, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
    - NCCI edits were run to identify if the disputed charges contain edit conflicts.
    - Per Medicare guidelines procedure code A4556 is an item or service that has no separate payment under the physician fee schedule. Reimbursement is therefore not recommended for HCPCS code A4556.
    - CPT codes 99202, 95861, 95900 and 95904 did not contain NCCI edit conflicts and will therefore be reviewed according to the applicable guidelines.
3. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting... Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."
    - For every service that is assigned a value by Medicare there is a specific reimbursement amount in the workers' compensation system. The reimbursement will vary depending upon the geographic area where the service is provided. Review of box 32 of the CMS-1500 documents that the services were rendered in El Paso, Texas, zip code 79925. Medicare does not have an El Paso locality; therefore the Rest of Texas is selected to determine the Medicare reimbursement for the disputed CPT codes.
    - The requestor billed CPT code 99202 in the amount $114.97. The insurance carrier issued payment in the amount of $110.36. The DWC's fee guideline reimbursement is $110.36, therefore no additional reimbursement is recommended.
    - The requestor billed CPT code 95861 in the amount $211.60. The insurance carrier issued payment in the amount of $203.29. The DWC's fee guideline reimbursement is $203.29, therefore no additional reimbursement is recommended.
    - The requestor billed CPT code 95900 x 4 units in the amount $370.40. The insurance carrier issued payment in the amount of $92.33 for one unit x 4 units =$369.32. The DWC's fee guideline reimbursement is $92.33/unit x 4 units =$369.32. The insurance carrier paid the fee guideline reimbursement amount, therefore no additional reimbursement is recommended.
    - The requestor billed CPT code 95904 x 4 units in the amount $340.38. The insurance carrier issued payment in the amount of $81.29 /unit x 4 units = $325.16. The DWC's fee guideline reimbursement is $81.29/unit x 4 units = $325.16. The insurance carrier reimbursed the requestor the fee guideline reimbursement amount; therefore no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.